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An illustrative discussion is based on New Mexico's program in community mental health consultation, the aim of which is to provide expert mental health consultation to ongoing community services, to participate in professional and public education, and to conduct community organization activities.

Rural community expectations about specific professional practices are ambiguous; therefore mental health programs should encourage community participation, should be understood by the community, and should avoid too much specialized help. Helping troubled people in rural communities is a direct process which implies that to have an impact on youth, program consultants should work with those who work with youth; they should emphasize simplicity, flexibility, and warmth. The readiness of the rural community to accept innovation is another factor that should enhance the chances of success of a well-planned mental health program.

The community consultant approach is illustrated by two projects: the Las Cruces, New Mexico project, where non-professional community project leaders were trained; and a rural project in eastern New Mexico, which concentrated on providing services to small, widely separated communities.

A student exchange program should be conducted between rural and urban youth. The rural youth would obtain a morale boost from knowing that someone was living in his community to gain a special experience, and he would adjust better if he later moved to an urban setting.

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DEVELOPMENT OF SERVICES FOR MEETING MENTAL HEALTH NEEDS AMONG RURAL CHILDREN AND YOUTH

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DEVELOPMENT OF SERVICES FOR MEETING MENTAL HEALTH NEEDS AMONG RURAL CHILDREN AND YOUTH

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ABSTRACT

Rural mental health programs generally are believed to be absent or at best undeveloped in contrast to affluent metropolitan facilities, staffs, and services. The major hypothesis of this background paper is that rural settings have untapped potential in the role of demonstrating, experimenting, and pioneering new philosophies, methods, and goals in the mental health field. These philosophies emphasize the responsibilities of professionals in mental health areas to broaden their skills in community organization, train persons in parallel professions, and consult with an expanding roster of mental health guardians. Methods should stress economy, simplicity, flexibility, warmth, and practicability. Our goals should be to extract from the clinical model those effective ingredients of therapy which may be utilized by the allied mental health professions, and, wherever possible, by any existing community resources. The rural setting is particularly suited for programs of this nature.

INTRODUCTION

Our discussion relies heavily upon New Mexico's current program in community mental health consultation. Its major service aim has been to provide a mental health consultant as a full-time, locally-based professional resource person to a multi-county area, quite distant from the State's centers of professional practice and which has no other mental health facilities or practitioners. The program was started in 1959. Case consultation is provided to local health, welfare, education, and law enforcement agencies and to practitioners in medicine, law, and the clergy; the consultants serve as information-education resources; they conduct in-service training for related professions; and they assist their communities in expanding or improving those facilities conducive to constructive mental health. To supplement the full-time services of the district consultant, we have a part-time consulting psychiatrist who goes to each district one day per month (because of the vast distances involved, we are fortunate that he flies his own plane).

The district consultation service is not a clinical facility; its aim is to provide expert mental health consultation to ongoing community services, engage in public and professional education, and conduct community organization activities. This approach is analogous to the philosophy of the "county agent" in the field of agriculture.

This program, in a state having such a paucity of mental health services (we are the only state without even one full-time outpatient clinic), was logical in the light of manpower shortages, vast distances separating the population centers (making unfeasible the idea of a traveling clinic team -- both because the team gets exhausted and because the local community, so distant from "state headquarters," does not develop its own resources), and a general lack of professionally qualified supporting agencies and practitioners. Rather than attempt to handle mental health problems directly, our community consultants seek to mobilize and assist existing agencies to do so more effectively. Nevertheless, the expressed need for something to be done about a community's behaviour problems (referral, treatment, removal, custody) made a consultation, education, and community organization approach definitely innovative in view of desires for clinic services. Overworked nurses, pediatricians, probation officers, school guidance counselors, and welfare workers wanted another "pair of hands" for easing (through referral) rather than increasing (through consultation) the caseload burdens of their agencies.

CHARACTERISTICS OF RURAL COMMUNITIES PERTAINING TO MENTAL HEALTH PROGRAMS

During the course of our project certain characteristics of our rural communities have become generally apparent.

The first characteristic is that community expectations about specific professional practices are largely ambiguous. Generally the experience of rural people is limited to a family member, relative, or distant friend going away for psychiatric treatment. Most of these friends or relatives of patients have had little direct involvement in the treatment process. Exposure to mass media

discussion of mental health services leaves much variance in understanding from individual to individual, and expectations regarding mental health practices seem less entrenched, probably because most rural communities do not have traditional forms of psychiatric facilities.

Numerous implications for developing mental health services follow from these observations. To a mental health professional deeply immersed in preconceived notions of traditional services, the absence of psychiatric facilities is inconceivable. However, for those who depart from this traditional view, exciting alternatives for community mental health programs emerge. Our interpretation is that mental health problems are: (1) a community responsibility and are interrelated with social, economic, political, and spiritual concerns that (2) must be understood by the community in which they happen, and which must be (3) solved with the raw materials out of that setting with (4) a minimum of "take over" by forms of specialized help. This interpretation encourages optimal opportunity for broader community participation. As has been amply documented in community organization research, participation in community affairs is essential not only for community benefit but for individual benefit as well.

The second characteristic of rural communities is closely related to the first. Helping troubled people is very direct in rural communities since the helping persons whom they contact do not have to wade through a vast network of mental health facilities and undergo the potentially impersonalizing and iatrogenic processes that can occur in specialized agencies. Working primarily with the mental health guardian group is particularly important in rural settings and for urban settings as well. The University of Michigan study Americans View Their Mental Health revealed that the psychiatrists and social agencies in both rural and urban settings were last resorts. 1/ The front line mental health guardians are ministers, physicians, and other mental health-related professionals. Why is this direct action characteristic especially pertinent to development of services for mental health needs among rural children and youth?

Let us examine the rural youngster. He is extremely community oriented. His educational, religious, social, economic, and political concerns are welded very closely together. Acquaintance with community officials is extensive and he probably knows the mayor, chief of police or sheriff, city and county commissioners, and other community officials. The extra-family people who influence him day in and day out are the teacher, minister, family doctor, policeman, and juvenile officer (especially if he comes from a low-income family), employer, town druggist, merchants, little league coaches, and other adults who congregate at informal business and social meeting places. One could say this does not differ significantly from urban youth, but closer examination often shows that rural youth's range of choices with respect to his ideologies, values, goals, and social-psychological characteristics are more limited than his urban counterpart. However, what the choices lack in breadth some times are made up for in the depth and permanence of his community life. Although fewer in number, his relationships seem to have deeper significance in their impact than those in urban life. Four conclusions of major importance to rural mental health services may be derived from these observations:

(1) To have the greatest impact with youth, work with those who work with youth. (2) In working with rural youth it is possible to have greater control over the variables affecting him, due to the fact that his relationships are fewer and that the milieu is more manageable and understandable than in more complicated settings. (3) Specialized professional treatment of mental health problems in such a setting is remote from familiar values, motivations, and needs (e.g., the typical clinical approach with its diagnostic studies, interdisciplinary teams, and prolonged "talking therapy" seems strange to the small town orientation). (4) The qualities of economy, simplicity, flexibility, warm atmosphere, and practicability are part and parcel of our rural communities.

The third characteristic of rural communities is readiness. Our feeling is that there has been a rural transition in the past three or four decades. This is manifested in several ways -- a readiness to accept innovation not only in farming technology and household furnishings, but also in the realm of ideas. For example, our district mental health consultants found rural people seeking specialized services despite their distance from home community. Generally speaking, there is also a readiness, even an eagerness, to develop programs at home. Dr. Evon Z. Vogt in his book Modern Homesteaders 2/ found that living for the future was a major value-orientation in a small, homogenous village of western New Mexico. The associated value of "Be progressive" has been a dynamic element since the very earliest days of that settlement. The progressive value orientation is clearly expressed in the homesteader's attitudes toward illness and treatment. As Dr. Vogt notes, "In the treatment of illness there is some use of home remedies and of patent medicines purchased in the local stores, but by and large the Homesteaders are oriented strongly toward the use of the latest medicines and medical facilities when sickness does occur." 3/

Our experience with even some of the most isolated rural families was most pleasantly surprising. It is, in fact, one of the most significant findings of our project that the receptiveness of the lay community exceeds the receptiveness of the mental health guardian group. Existing agencies and institutions were more difficult to work with than were the ultimate clients. This is another reason why we feel that in a rural setting the consultant's focus on broad contacts in local communities including guardian, client, as well as professionals enhances program effectiveness, increases communication, mobilizes and coordinates existing resources, and encourages optimal deployment of manpower.

COMMUNITY CONSULTANT PROGRAMS

As an illustration of this approach, we wish to describe two major projects initiated by our district mental health consultants.

THE LAS CRUCES PROJECT

The first project focused on training non-professional community project leaders and originated in Las Cruces, New Mexico, a setting which presents many typical problems of a small city in transition (it has grown from approximately 8,000 population after World War II to over 35,000 in 1962). Until the Community Mental Health Consultant was assigned to the County Health Department late in 1959, it had no one whose exclusive concern was with the mental

health needs of the population. It had no private practitioners in the field of psychiatry or psychology. There had been many attempts to recruit qualified personnel in these specialties around whom Las Cruces might mobilize and build programs. All attempts were unsuccessful. The project placed a mental health consultant in the community to explore the effectiveness of specific methods of selecting, assigning, training, and giving consultation to nonprofessional mental health workers so they and other members of the community revise existing resources and develop new home town programs, activities, and services related to mental health needs.

Las Cruces has the first three trainee-workers, a coordinator of services and personnel for a day care center for emotionally disturbed children, an executive secretary for a local mental health sponsoring agency, and a youth work coordinator to develop a preventive program for children in conflict. In the second year and each year thereafter through the fourth year of the project, additional trainees will be added.

Community service projects are based on certain considerations such as need, community appeal, sponsorship, potential for success, strengthening existing organizations, etc., and trainees, also selected according to certain criteria, are assigned to these service projects. Total staff includes a director (mental health nurse, 80 percent of whose time will be on this project), a codirector (consultant public health psychiatrist, 20 percent time on this project), a program analyst (borrowed from New Mexico State University, 20 percent time), a coordinator (nonmental health professional, 100 percent time), and an executive secretary (also nonmental health professional, 100 percent time). In addition to its potential contribution to new methods of coping with the critical manpower situation, the local planning and participation skills of this community will be highly sharpened.

THE RURAL PROJECT

The second project originated in the eastern part of New Mexico on the West Texas border and is 100 miles on the Texas side and 200 miles on the New Mexico side from any specialized resources. The project is based in Eastern New Mexico University which has an enrollment of 2,200 students. This program concentrates on providing workable services to very small, widely separated communities. Techniques for coping with a variety of emotional problems as designed by a University-community-state agency triad will be developed and evaluated. This project combines the consultant format (i.e., field consultant) with an interdisciplinary specialized nucleus team approach but concentrates on field methods rather than clinical procedures.

Both of these projects are so designed as to minimize "taking over a case" and to maximize the use of mental health resources for children in hazard. The major energies are focused on people in the community who have the most significant roles in the children's mental health needs. The addition of new organizations is kept to a level practical to the situation. Simplicity and warmth are key notes.

As readers of this paper well know, working as a professional in a small

town exposes one to all kinds of hazards and functioning in this setting is extremely hard work. The consultant must play many roles that constantly shift without advance notice as he attempts to relate to the total community. Our consultants are more thoroughly ego-engaged, more visible as individuals, and more acutely reactive to the joys and sorrows of program vicissitudes than most professionals experience in the more insulated institutional environments in which we were trained.

THE FUTURE OF COMMUNITY CONSULTANTS

What about tomorrow? Is the consultant format so progressive that it needs no new innovation? Obviously, we need to move ahead, so, let's for the moment fantasize. What would happen if the positive elements of a rural setting were combined with the positive elements of an urban setting? Would this alter the more pervasive and less distinguishable element called "predominant community attitude?" We would speculate that overall mental health of a loose urban neighborhood and the overall mental health of a tight rural community or town would show signs of improvement. To us youth represent a vital force in our society and efforts directed toward them have present and future benefits.

Allow us to suggest a student exchange program between rural and urban youth similar to our foreign student exchange idea. If properly structured, the urban youth would develop greater perspective about the role of his neighborhood in the overall relationship it has to his city. He would have an experience in depth with community life that would prepare him for citizen participation in his own urban setting.

The rural youth would have an experience in breadth as well as the opportunity to look at his home town from a distance. From the standpoint of morale knowing that someone is living in his community to gain a special experience may contribute to his home town pride and also minimize the negative "I'm just a small town rube" attitude. In the event he later decides to leave his home town he will be much better prepared for urban adjustment.

This exchange idea is offered as an illustration of the preventative direction that mental health services should take us. The increasing attention given to prevention is especially fortunate for rural mental health programming, and we should make every effort to capitalize upon it with imagination, courage, and creativity. To some these kinds of programs may seem remote from what we not only respect but also cherish, and giving up old ways may be harder for us than the people we must serve.

FOOTNOTES

1. Gurin G., Joseph Veroff, and Sheila Feld. Americans View Their Mental Health, Monograph Series No. 4., Joint Commission on Mental Illness and Health, New York: Basic Books, Inc., 1960, p. 341.

2. Vogt, Evon Z. Modern Homesteaders, Cambridge, Massachusetts: The Belknap Press of Harvard University Press, 1955, p. 75.

3. Ibid.

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